SC Department of Disabilities and Special Needs

Request for Reinstatement of Employee Form

Provider:

Name of Employee Recommended for Reinstatement:	
Date of Incident:	**If Date of Incident is unknown, indicate date incident was reported** (also shown on Initial Report):

Name(s) of Alleged Victim(s) Involved in Incident:

Reason employee should be reinstated:

Provider Signature:

_____ _____

Executive Director/ CEO/ Facility Administrator Date

Central Office Action Regarding Employee Reinstatement:	**Signatures:**
☐Approved Comments: ☐Disapproved Comments:	_____ _____ Office of Quality Management Date _____ _____ Office of Quality Management Date
☐Approved Comments: ☐Disapproved Comments:	_____ _____ Office of Policy Date _____ _____ Office of Operations Date _____ _____ Office of Policy Date _____ _____ Office of Operations Date

Note: A separate form should be completed for each employee where employment reinstatement is being requested.

Send completed form to:

Director of Quality Management, SCDDSN, PO Box 4706, Columbia, SC 29240, FAX #: (803) 898-7450.